Name: _____

Chart #: _____

St. Croix County Reproductive Health Services (SCCRHS)

Consent for Care

This is an Equal Opportunity Program. If you believe that you have been discriminated against because of age, race, color, handicap, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, or religion, write immediately to this office at 1752 Dorset Lane, New Richmond, Wisconsin 54017. If you are not satisfied or if you do not receive a response in approximately thirty (30) days, you may file a written complaint with DHHS, Affirmative Action/ Civil Rights Compliance Office, PO Box 7840, Madison, Wisconsin 53707.

Financial Agreement: I agree to reimburse SCCRHS for services on the basis of my financial ability, in a timely manner, using the fee scale to determine an equitable amount. I will inform SCCRHS of any changes in my financial status which may affect my ability to reimburse SCCRHS. I agree to allow SCCRHS to bill and receive payment from the state of Wisconsin, if I am enrolled in any state funded program, and other insurance payors. (See fee guide on reverse side.)_____
initials

Liability Disclaimer: SCCRHS is not responsible for the actions of individuals not directly employed by SCCRHS, nor the effects, side effects, or complications of any contraceptive method.

Informed Consent: I understand that it is my responsibility to read all information, including package inserts and/or medication fact sheets given to me by SCCRHS.

Examination and Laboratory testing: I authorize SCCRHS to examine and/or perform laboratory testing and/or provide treatment and/or a method of contraception to me. I understand SCCRHS is required by law to report communicable diseases to the state of WI.

Human Immunodeficiency Virus Testing (HIV): SCCRHS provides HIV testing and I understand that this testing is available to me upon request and evaluation.

Teaching Facility: St. Croix County is a teaching facility and I understand that I may receive services from a student under the direct supervision of SCCRHS staff.

Research/Study Projects: SCCRHS participates in research/study projects and may use non-identifying personal health information for statistical purposes required for the research/study. Research projects will have Internal Review Board approval if required.

Termination: I understand that I may terminate my consent at any time by giving written notice to SCCRHS.

My signature below indicates that I have read the above, understand it, had the opportunity to ask questions and have them answered. I agree and consent to the above and to the services provided by SCCRHS.

Signature of Client: _____ Date:_____

Witness: _____ Date:_____